AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Good Samaritan Hospital **to release medical information from the records of:**

(Name of Facility)

Patient Name: Daniel Chavez **D.O.B.** April 29, 1995 **SS#** 521-97-4025

Patient Street Address:9758 Loredo st unit 35 D **City**: commerce city **State:** CO **Zip Code**: 80022

Date(s) of Treatment Requested: 03/31/2023 - Present

Information to be disclosed (check all applicable items to be released):

☒Discharge Summary	☒ER Record	☒Progress Notes	☒Treatment Plans
☒Discharge Instructions	☒X-Rays Reports	☒Medication Records	☒Commitment Papers
☒History and Physical	☒Lab Reports	☒Doctor's Orders	☐HIV Testing
☒Consultations	☒EKG/ECG Tests	☒Nurse's Notes	
☒Operative Report	☒Therapy Notes		

☒Other (please specify): Billing

Purpose Or Need For the Disclosure Is:

☐Continued Medical Care ☐Insurance XLegal ☐Patient's Own Use ☐Other_____

The Information May Be Disclosed To:

Ramos Law
10190 Bannock St.., Suite 200
Northglenn, CO 80260
PH: (303) 733-6353
FX: (303) 865-5666

My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, and enrollment in a health plan or my eligibility for health care benefits. However, information will not be released to the above-indicated recipient without my signature.

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.

I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires on:_____ **or upon the following event:** CASE SETTLEMENT

(Date)

(If no date is specified, this authorization will expire in six months from the date of signature).

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

Fees: I understand and agree that there may be costs associated with this request in compliance with State copying laws.

DocuSigned by:
4C025B50-0059450...

(Signature of Patient or Personal Representative)* 04/07/2023 *(Date of Signature)*

*** If signed by a personal representative, a description of the representative's authority to act is as follows:**

☐Parent ☐Legal Guardian ☐Health Care Power of Attorney
☐Administrator ☐Executor of Estate ☐Next of Kin ☐Beneficiary

03/31/2023 - ED in Good Samaritan Medical Center - Emergency Medicine Services - SCL Health

Reason for Visit

Chief Complaint

- Motor Vehicle Crash

Visit Diagnoses

Name	Code	Qualifier	Is ED?
Blunt head trauma, initial encounter (primary)	S09.8XXA	Acute	Yes
Contusion of right hand, initial encounter	S60.221A	Acute	Yes
Motor vehicle collision, initial encounter	V87.7XXA	Acute	Yes

Visit Information

Admission Information

Arrival Date/Time:	03/31/2023 0705	Admit Date/Time:	03/31/2023 0705	IP Adm. Date/Time:	
Admission Type:	Emergency	Point of Origin:	Non Health Care Facility Point Of Origin	Admit Category:	
Means of Arrival:	Ambulance	Primary Service:	Emergency Medicine	Secondary Service:	N/A
Transfer Source:		Service Area:	SCL HEALTH	Unit:	Good Samaritan Medical Center - Emergency Medicine Services - SCL Health
Admit Provider:		Attending Provider:	Tyler Aronstein, DO	Referring Provider:	

ED Disposition

ED Disposition	Condition	User	Date/Time	Comment
Discharged	--	Tyler Aronstein, DO	Fri Mar 31, 2023 8:11 AM	Daniel Chavez discharge to Home/Self Care

Discharge Information

Date/Time: 03/31/2023 0905 Disposition: Home Or Self Care Destination: —
Provider: Tyler Aronstein, DO Unit: Good Samaritan Medical Center - Emergency Medicine Services - SCL Health

Follow-up Information

Follow up With	Specialties	Details	Why	Contact Info
Edward G Kim		In 1 week		10350 E DAKOTA AVE Denver CO 80247-1314

Medication List

Medication List

This report is for documentation purposes only. The patient should not follow medication instructions within. For accurate instructions regarding medications, the patient should instead consult their physician or after visit summary.

Prior To Admission

None

Discharge Medication List

naproxen (NAPROSYN) 500 mg tablet

Instructions: Take 1 tablet (500 mg) by mouth in the morning and 1 tablet (500 mg) before bedtime.
Authorized by: Tyler Aronstein, DO Ordered on: 3/31/2023
Start date: 3/31/2023 Quantity: 30 tablet
Refill: No refills remaining

methocarbamoL (ROBAXIN) 500 mg tablet

Medication List (continued)

Instructions: Take 1 tablet (500 mg) by mouth every six hours, as needed for Muscle spasms
Authorized by: Tyler Aronstein, DO
Ordered on: 3/31/2023
Start date: 3/31/2023
Quantity: 30 tablet
Refill: No refills remaining

Stopped in Visit

None

Clinical Notes

Discharge Instructions

Tyler Aronstein, DO at 3/31/2023 0811

Electronically signed by Tyler Aronstein, DO at 3/31/2023 8:11 AM

ED Provider Note

ED Provider Notes by Tyler Aronstein, DO at 3/31/2023 0710

US Acute Care Solutions
USACS Colorado West
www.usacs.com

Good Samaritan Medical Center
Department of Emergency Medicine
200 Exempla Cir
LAFAYETTE, CO 80026-3370
303-689-4000

Patient: Daniel Chavez **DOB:** 4/29/1995
MRN: S0619595 **CSN:** 251505512

PCP: Edward G Kim
Visit Date: 3/31/2023

CHIEF COMPLAINT

Chief Complaint

Patient presents with

- Motor Vehicle Crash

HPI

History obtained by:

patient

Daniel Chavez is a 27yr male who presents to the emergency department for evaluation of a headache. The patient was restrained driver of a vehicle involved in T-bone type accident. There was airbag deployment. The patient is reporting pain in his right hand. He does report a minor headache as well. He did strike his left temple on part of the

car but is reporting just a mild right-sided headache. He denies any numbness, tingling, weakness, antiplatelet use or anticoagulation use. He otherwise has no complaints or concerns at this time.

REVIEW OF SYSTEMS

Review of Systems
HENT: Negative for ear pain and sore throat.
Eyes: Negative for pain.
Respiratory: Negative for shortness of breath.
Cardiovascular: Negative for chest pain.
Gastrointestinal: Negative for abdominal pain.
Genitourinary: Negative for dysuria and flank pain.
Musculoskeletal: Negative for back pain and neck pain.
Neurological: Positive for headaches.

PAST MEDICAL HISTORY

No past medical history on file.

SOCIAL HISTORY

Social History

Socioeconomic History	
• Marital status:	Married

SURGICAL HISTORY

No past surgical history on file.

CURRENT MEDICATIONS

Prior to Admission medications

Medication	Sig
methocarbamoL (ROBAXIN) 500 mg tablet	**Take 1 tablet (500 mg) by mouth every six hours, as needed for Muscle spasms**
naproxen (NAPROSYN) 500 mg tablet	**Take 1 tablet (500 mg) by mouth in the morning and 1 tablet (500 mg) before bedtime.**

ALLERGIES

No Known Allergies

PHYSICAL EXAM

VITAL SIGNS:

Vitals:

	03/31/23 0710
BP:	**(!) 153/91**
Pulse:	99
Resp:	16
Temp:	98.8 °F (37.1 °C)
SpO2:	97%

Physical Exam

Vitals and nursing note reviewed.

Constitutional:
General: He is awake.
Appearance: He is not ill-appearing or toxic-appearing.

HENT:
Head: Normocephalic and atraumatic.
Right Ear: External ear normal.
Left Ear: External ear normal.
Nose: No congestion or rhinorrhea.
Mouth/Throat:
Mouth: Mucous membranes are moist.

Eyes:
General: No scleral icterus.
Conjunctiva/sclera:
Right eye: Right conjunctiva is not injected.
Left eye: Left conjunctiva is not injected.

Neck:
Trachea: No tracheal deviation.

Cardiovascular:
Rate and Rhythm: Normal rate and regular rhythm.
Pulses: Normal pulses.

Pulmonary:
Effort: Pulmonary effort is normal.
Breath sounds: Normal breath sounds. No wheezing, rhonchi or rales.

Chest:
Chest wall: No tenderness or crepitus.

Abdominal:
Palpations: Abdomen is soft.
Tenderness: There is no abdominal tenderness. There is no guarding or rebound.

Musculoskeletal:
Cervical back: Neck supple.
Comments: **No tenderness to cervical, thoracic, or lumbar spine. No bony step-off. Full range of motion to cervical spine including flexion, extension, and rotation. Slight tenderness at the right fifth metacarpal. otherwise no tenderness to remainder of bilateral clavicles, chest wall, and bilateral upper and lower extremities. Pelvis stable to compression. 2+ b/l radial, DP, and femoral pulses.**

Skin:
General: Skin is warm.
Capillary Refill: Capillary refill takes less than 2 seconds.

Neurological:
Mental Status: He is alert and oriented to person, place, and time.
GCS: GCS eye subscore is 4. GCS verbal subscore is 5. GCS motor subscore is 6.
Cranial Nerves: Cranial nerves 2-12 are intact.

Psychiatric:
Behavior: Behavior is not agitated or aggressive.

Pulse Ox: >91%, my interpretation is adequate oxygenation

Procedures

ED COURSE
1:52 PM

Clinical Impressions as of 03/31/23 1352
Blunt head trauma, initial encounter
Contusion of right hand, initial encounter
Motor vehicle collision, initial encounter

MEDICAL DECISION MAKING
Summary:

The patient's history, examination, and workup is consistent with a headache. Headache is moderate mechanism to this car crash. The patient is complaining about a headache and is having some hand pain. Shared decision-making was utilized and elected proceed with a CT scan of the patient's head secondary to mechanism and headache. This is negative for any intracranial hemorrhage. X-rays negative for fracture dislocations. Do suspect a hand contusion. Discussed PR ICE therapy. Patient has no neck tenderness in his neck was cleared clinically.

Reviewed images with one positive or negative finding:

I reviewed all radiology reports (interpreted by radiologist) listed below. I personally reviewed x-ray of the hand without any displaced fracture, CT scan of the head without any large intracranial hemorrhage which are also interpreted by me.
XR Hand Unilateral 3 Views

Result Date: 3/31/2023
RIGHT HAND RADIOGRAPHS VIEWS: THREE EXAM DATE AND TIME: 3/31/2023 7:47 MDT INDICATION: Right hand pain. Pain in the region of the fifth metacarpal. EPISODE OF CARE: Initial. COMPARISON: None. FINDINGS: No fracture, dislocation or osseous or soft tissue abnormality is identified in the right hand. Mineralization is normal. Articular surfaces are maintained without erosion. IMPRESSION: 1. Negative for acute bony abnormality. THIS DOCUMENT HAS BEEN ELECTRONICALLY SIGNED: JOHN C. RICHARDS, MD 3/31/2023 8:01 MDT Contributed By:

CT Head w/o Contrast

Result Date: 3/31/2023
CT HEAD WITHOUT CONTRAST EXAM DATE AND TIME: 3/31/2023 7:55 MDT INDICATION: Trauma. COMPARISON: None. TECHNIQUE: CT images of the brain were acquired in the axial plane. Dose reduction techniques were employed. FINDINGS: INTRACRANIAL CONTENTS: There is no evidence of acute territorial infarct, intracranial hemorrhage, or significant intracranial mass effect. Normal white matter for age. There is no evidence of hydrocephalus. Mildly prominent midline posterior fossa CSF space may reflect mild anatomic variant mega cisterna magna versus small incidental arachnoid cyst. CALVARIUM: No acute calvarial fractures. EXTRACRANIAL STRUCTURES: There are no acute findings of the visualized portions of the orbits or extracranial soft tissues. IMPRESSION: 1. No evidence of acute intracranial abnormality. Specifically, no intracranial hemorrhage, mass lesion, or evidence of evolving large territorial infarct. This study was interpreted by an ABR certified radiologist with subspecialty training in neuroradiology. Physicians or other medical providers may call 720-493-3777 with any questions. THIS DOCUMENT HAS BEEN ELECTRONICALLY SIGNED: NATHAN COLEMAN, MD 3/31/2023 8:06 MDT Contributed By:

Reviewed labs

All the labs listed below are reviewed and interpreted by me (in conjunction with patients presentation and

workup).
No results found for this visit on 03/31/23.

Physical exam findings related to presenting problem:
As above

Vitals:

	03/31/23 0710
BP:	**(!) 153/91**
Pulse:	99
Resp:	16
Temp:	98.8 °F (37.1 °C)
SpO2:	97%

Social issues affecting care:
none

ED prescriptions:
Discharge Medication List as of 3/31/2023 8:19 AM

START taking these medications

	Details
methocarbamoL (ROBAXIN) 500 mg tablet	Take 1 tablet (500 mg) by mouth every six hours, as needed for Muscle spasms, Disp-30 tablet, R-0, Normal
naproxen (NAPROSYN) 500 mg tablet	Take 1 tablet (500 mg) by mouth in the morning and 1 tablet (500 mg) before bedtime., Disp-30 tablet, R-0, Normal

FINAL IMPRESSION

1. **Blunt head trauma, initial encounter Acute**
2. Contusion of right hand, initial encounter Acute
3. Motor vehicle collision, initial encounter Acute

ED Disposition

ED Disposition	Condition	Comment
Discharged	--	Daniel Chavez discharge to Home/Self Care

Contact information for follow-up

EDWARD G KIM
Relationship: PCP - General
Next Steps: Follow up in 1 week(s)

10350 E DAKOTA AVE
DENVER CO 80247-1314

Electronically signed by:

ED Provider Note (continued)

Tyler Aronstein, DO
3/31/2023

Electronically signed by Tyler Aronstein, DO at 3/31/2023 1:52 PM

Last 3 Days of Notes from 3/28/2023 to 4/10/2023

Scanned Note Null from 3/28/2023 to 4/10/2023

Filed on 3/31/2023 0800 from 3/28/2023 to 4/10/2023

Scan on 3/31/2023 8:00 AM (below)

AGREEMENT FOR TREATMENT, EXAMINATION, AND ADMISSION

DEFINITIONS: All references in this consent form to "SCL Health" shall mean Sisters of Charity of Leavenworth Health System, Inc. and any and all of its controlled affiliates, including but not limited to its hospitals and clinics.

AGREEMENT FOR MEDICAL EXAMINATION - TREATMENT CONSENT, REPORTING REQUIREMENTS OF CERTAIN MEDICAL CONDITIONS AND INDEPENDENT CONTRACTOR STATUS OF SOME HEALTHCARE PROVIDERS.

This "Agreement for Medical Examination - Treatment Consent, Reporting Requirement for Certain Medical Conditions and Independent Contractor Status of Some Healthcare Providers" section gives SCL Health and affiliated Clinicians permission to perform medical treatments, procedures, examinations and tests on you as explained below:

- I understand that my care is under the supervision and control of my attending/treating physician(s) and/or health care providers such as Physician Assistants or Nurse Practitioners (collectively "Clinicians"), as allowed by law.
- I give permission for all medical treatments, procedures, examinations including X-Ray/medical imaging, administration of drugs, and/or any other diagnostic or therapeutic tests reasonably necessary for my proper care, including HIV testing. I understand that all of these procedures and/or tests may be done on an inpatient, observation or outpatient basis while I am in the hospital and on an outpatient basis after my discharge from the hospital or as a clinic patient without regard to any hospital status. My permission is given for continued procedures and tests on a recurring or on an as needed/as individually ordered basis. I understand that I have the right to more complete information concerning any particular diagnostic or therapeutic procedure and I may be asked for a more specific consent (verbal or written) to such procedures.
- I understand and agree that there may be circumstances under which the Clinician(s) or the hospital/health care facility is required to report to outside third parties such as health departments or the Center for Disease Control and Prevention (CDC) information pertaining to communicable diseases such as HIV, TB, and viral meningitis. I understand that disclosure of my Federal Social Security Number in reference to Medical Devices is required by the FDA under the Safe Medical Devices Act of 1990 and also for other state and federally mandated requests.
- I give permission that aspects of my care and treatment may be recorded and/or filmed for internal SCL Health purposes, such as medical/nursing student education or for quality purposes.
- I understand that no person has the authority to alter or amend this paragraph or any other paragraph in any manner.
- I give permission to the disposal by SCL Health of any tissues or parts which may be removed in the course of any procedure performed upon me. Body fluid exposures will be managed according to the laws of the state in which the SCL Health facility is located or by other applicable law.
- If I am pregnant I also give permission for testing and treatment of my unborn child and my newborn infant – all of this form applies equally to me, my unborn child, and my newborn infant.

I recognize and understand that all Clinicians furnishing services to me, including, but not limited to, my attending physicians, other physicians holding clinical privileges at this facility or clinic, and other physicians such as those providing services to me in anesthesiology, radiology, pathology and emergency medicine, may be independent contractors and are not the employees or agents of SCL HEALTH or of each other while providing professional services. I am signing this form with the understanding that SCL HEALTH and the Clinicians are providing services to me in express reliance on this written statement/my signature.

CERTIFICATION OF AGREEMENT TO BE BOUND BY THIS AGREEMENT

I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULT OF TREATMENT OR SERVICES PROVIDED OR TO BE PROVIDED TO ME. I CERTIFY THAT I HAVE READ THE ABOVE AGREEMENT (OR IT HAS BEEN READ TO ME) AND I UNDERSTAND WHAT IT SAYS. MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I HAVE BEEN OFFERED A COPY OF THIS DOCUMENT. I CERTIFY THAT I AM THE PATIENT OR PERSON DULY AUTHORIZED BY THE PATIENT TO EXECUTE THIS AGREEMENT AND I AGREE TO ITS TERMS.

Select the person signing the form ✓ Signature complete!

☐ Verbal Consent

☐

Patient ☑ CHAVEZ , DANIEL

Other ☐

Relationship to Patient: Self

Reason Patient Unable to Sign: --

Patient or Authorized Representative Signature
Electronically signed on 03/31/2023, 7:59 AM

2nd Witness Signature
Witness: Electronically witnessed by:
Lawrence, Suellen: S061526
03/31/2023 07:59:10 am

SCL Health
GOOD SAMARITAN
Agreement For Treatment, Examination, and Admission
EH-FR-TX-0678-1117-SCLHS

S0619595 Emergency 251505512
CHAVEZ , DANIEL
27 y 4/29/1995 M ADM: 3/31/2023
ARONSTEIN, TYLER

Electronically signed by Edi, Scan Document In at 3/31/2023 8:00 AM

Filed on 3/31/2023 0800 from 3/28/2023 to 4/10/2023

Scan on 3/31/2023 8:00 AM (below)

AGREEMENT FOR ASSIGNMENT OF INSURANCE BENEFITS

DEFINITIONS: All references in this consent form to "SCL Health" shall mean Sisters of Charity of Leavenworth Health System, Inc. and any and all of its controlled affiliates, including but not limited to its hospitals and clinics.

SECTION 1. ASSIGNMENT OF INSURANCE BENEFITS

This "Assignment of Insurance Benefits" allows SCL Health to bill your insurance company and for your insurance company to pay SCL Health as explained below: I for myself or for the patient (referred to as "I" or "Patient" or "me" or "my") give my permission for my insurance company(ies) to make payment directly to SCL HEALTH of inpatient and outpatient hospital and/or clinic services and related benefits, including major medical, otherwise payable to me. I certify that information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is true and correct to the best of my knowledge. I irrevocably assign to SCL HEALTH all right, title and interest in compensation or payment received or to be received from any source as a result of injuries sustained by me, and any person or corporation having notice of this assignment is hereby authorized and directed to pay directly to SCL HEALTH the amount of any indebtedness due SCL HEALTH for services provided by them to me. Additionally, I understand and agree that each Clinical group, to include certain SCL Health affiliates, or individual health care providers/practitioner thereof (referred to as the "Clinicians" or "health care providers") who provide professional services to me will bill and collect for their own professional services separate and apart from SCL HEALTH facility charges, but subject to the authorizations granted by me in accordance with this agreement, and I hereby authorize and request that insurance benefits for medical and professional services, otherwise payable to me, be assigned and paid directly to the Clinicians who rendered care to me. In the case of Medicare benefits, payment may not exceed the maximum allowable charge as determined by the Medicare carrier.

SECTION 2. STATEMENT OF FINANCIAL RESPONSIBILITY/TRANSFER OF CREDITS

This "Statement of Financial Responsibility/Transfer of Credits" is your promise to pay for any services not covered by your insurance company as explained below: I understand the services provided by SCL HEALTH and/or the Clinicians, today or in the future, may or may not be paid for by my health plan or health insurance. If my health plan/insurance deems any or all of these services are not covered and/or not medically necessary for any reason, then I understand that I am personally financially responsible for payment of those services and/or supplies provided to me and I agree to be the guarantor of payment for all services rendered to me in accordance with the regular charges and terms of SCL HEALTH and the Clinicians for such services. If this agreement is executed by a spouse or a financial guarantor of the Patient, the spouse or the financial guarantor shall be jointly and severally liable with me (meaning that both I and my spouse or financial guarantor will be obligated to pay the Clinicians and SCL HEALTH), and by me or my personal representative signing this agreement, those persons, together with me, do hereby promise to pay the Clinicians and SCL HEALTH all amounts due and owing for my account. Although the Clinicians and/or SCL HEALTH may file insurance claims as a courtesy, I understand that the Clinicians and/or SCL HEALTH cannot accept responsibility for collecting insurance payments or for negotiating a disputed claim, unless a contractual or legal obligation of the Clinicians and/or SCL HEALTH provides otherwise. Insurance reimbursement is a contract between me and my insurance carrier and an insurance company's Usual, Customary and Reasonable ("UCR") allowables or fee schedules are generally established without regard to the Clinicians' or SCL HEALTH' charges except in circumstances where the Clinicians and/or SCL HEALTH have a contractual agreement(s) with a health plan that prohibits such collection of payment from me and/or the subscriber. Should this account be referred to an attorney or collection agency, reasonable attorney's fees and/or collection expenses shall be payable by me in addition to any other amounts due. I hereby authorize the transfer of monies paid to SCL HEALTH by me or on my behalf and otherwise refundable to me, to be transferred to settle any indebtedness I owe to SCL HEALTH, for which I am responsible.

Continued on next page

SECTION 3. PERMISSION TO BE CONTACTED BY DIFFERENT METHODS TO INCLUDE MY CELL PHONE

This "Permission to be Contacted by Different Methods to Include My Cell Phone" allows SCL Health to contact me and how it will contact me as explained below: By signing below and as part of my admission, treatment, evaluation, diagnosis, prescriptions, testing and/or lab results ("Services"), "), I expressly understand, consent and agree that SCL HEALTH and its hospitals/clinics, affiliated physician groups, as well as any and all of their affiliates, sub-contractors, agents, labs, vendors, assigns, representatives, successors and debt collectors ("the Calling Parties") may call or contact me for any reason related to the provision of the above Services using an automatic telephone dialing systems, predictive dialer, artificial or prerecorded voice and/or prerecorded messages, via any electronic mail addresses through individual or automatically generated electronic mail, and via text messaging through individual and automatically generated text messages at (a) any cellular telephone number or land-line number or electronic mail address that I or any person acting on my behalf may provide to the Calling Parties at the time of, during, or after any hospital/clinic admission, follow up visit, telephone call, payment or address update, or (b) at any telephone number the Calling Parties can find me at in the future as a result of skip-tracing, call capture, caller ID technology, internet search engines, White Pages and/or similar search methods. This consent applies to all healthcare providers covered under this agreement. If I wish to revoke consent to call my cell phone, I agree to provide you notice of that revocation by emailing you at Donotcall@sclhealth.org, mailing it to SCL Health, Attn: Do Not Call-Self Pay, 500 Eldorado Blvd., Broomfield, CO 80021 or calling the toll free line at 1-866-665-2636. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto-dialer technology and/or prerecorded messages.

I AGREE TO BE BOUND BY SECTIONS 1, 2, AND 3.

Select the person signing the form ✓ Signature complete!

☐ Verbal Consent

☐

Patient ☑ CHAVEZ , DANIEL

Other ☐

Relationship to Patient: Self

Reason Patient Unable to Sign: --

Patient or Authorized Representative Signature
Electronically signed on 03/31/2023, 7:59 AM

2nd Witness Signature
Witness: Electronically witnessed by:
Lawrence, Suellen: S061526
03/31/2023 07:59:19 am

SCL Health
GOOD SAMARITAN
Agreement for Assignment of Insurance Benefits
Page 2 of 2
EH-FR-TX-0679-0819-SCLHS

S0619595 Emergency 251505512
CHAVEZ , DANIEL
27 y 4/29/1995 M ADM: 3/31/2023
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Electronically signed by Edi, Scan Document In at 3/31/2023 8:00 AM

Filed on 3/31/2023 0800 from 3/28/2023 to 4/10/2023

Scan on 3/31/2023 8:00 AM (below)

Patient Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "Balance Billing" (sometimes called "Surprise Billing")?

When you see a doctor or health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a healthcare facility that is not in your health plan's network.

"Out-of-network" describes providers and facilities that have not signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called **"balance billing"**. This amount is likely higher than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care, for example, when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from Balance Billing for:

1. **Emergency services**
   If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **cannot** be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

2. **Certain services at an in-network hospital or ambulatory surgical center**
   When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensives services. These providers **cannot** balance bill you and may **not** ask you to give up your protections not to be balance billed.

   If you get other services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

   You are <u>never required</u> to give up your protection from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

Continued on next page

3. Additional protections under Colorado State Law (applicable to Colorado-Based Health Plans only):

- Your insurer will pay out-of-network providers and facilities directly. You are only responsible for paying your in-network cost-sharing for covered services.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.
- Your provider or facility or agency must refund any amount you overpay within 60 days of being notified.
- Provider, hospital, or outpatient surgical facility cannot ask you to limit or give up these rights.

4. When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - ▷ Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - ▷ Cover emergency services by out-of-network providers.
  - ▷ Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - ▷ Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, please contact SCL Health Customer Service at 1-866-665-2636.
If we are unable to resolve your complaint, you may contact the No Surprises Helpdesk at 1-800-985-3059.

Please visit https://www.cms.gov/nosurprises/consumers for more information about your rights under Federal law.

Patients with Colorado-based health plans (your ID card will have “CO-DOI” printed on it) may also contact the Colorado State Division of Insurance at 303-894-7490 or 1-800-930-3745, or visit https://doi.colorado.gov/for-consumers/file-a-complaint

Select the person signing the form ✓ Signature complete!

☐ Verbal Consent

☐

Patient ☑ CHAVEZ , DANIEL ◉

Other ☐

Relationship to Patient: Self ◉

Reason Patient Unable to Sign: --

Patient or Authorized Representative Signature
Electronically signed on 03/31/2023, 7:59 AM

2nd Witness Signature
Witness: Electronically witnessed by:
Lawrence, Suellen: S061526
03/31/2023 07:59:40 am

SCL Health
GOOD SAMARITAN
Surprise Billing Disclosure – Colorado
Page 2 of 2
A-TX-4301-1121

S0619595 Emergency 251505512
CHAVEZ , DANIEL
27 y 4/29/1995 M ADM: 3/31/2023
ARONSTEIN, TYLER

Electronically signed by Edi, Scan Document In at 3/31/2023 8:00 AM

Treatment Team

Provider	Service	Role	Provider Team	Specialty	From	To
Tyler Aronstein, DO	Emergency Medicine	Attending Provider	—	Emergency Medicine	03/31/23 0710	03/31/23 0905

03/31/2023 - ED in Good Samaritan Medical Center - Emergency Medicine Services - SCL Health (continued)

Treatment Team (continued)

Provider	Service	Role	Provider Team	Specialty	From	To
Bryony C Gorsich, RN	—	Registered Nurse	—	—	03/31/23 0724	—
Angelica M Lopez, RN	—	Registered Nurse	—	—	03/31/23 0712	03/31/23 0724

ED Care Timeline

Patient Care Timeline (3/31/2023 07:05 to 3/31/2023 09:05)

3/31/2023	Event	Details	User
07:05	**Patient arrived in ED**		Suellen Lawrence
07:05	**Patient roomed in ED**	To room ED08	Suellen Lawrence
07:05:10	**Emergency encounter created**		Suellen Lawrence
07:05:27	**PATIENT SUMMARY EXTRACT**		Suellen Lawrence
07:05:43	**ED Reg Started**		Suellen Lawrence
07:09:10	**Triage Started**		Angelica M Lopez, RN
07:09:10	**Chief Complaints Updated**	**Motor Vehicle Crash**	Angelica M Lopez, RN
07:10	**Pain Assessment for Pain Alerts**		Angelica M Lopez, RN
07:10	**Pain Alert Assessment**	**Pain Alert Assessment Timer** Pain Alert Assessment : Yes	Angelica M Lopez, RN

03/31/2023 - ED in Good Samaritan Medical Center - Emergency Medicine Services - SCL Health (continued)

ED Care Timeline (continued)

07:10	**Triage Data**	**Distress Level** Distress Level: Moderate **History of Present Illness** History of Present Illness: Pt BIBA from scene of accident, per pt was driver of vehicle who tbone another vehicle approx 45mph. Restrained driver, airbag deploy, -LOC. Pt c/o headpain, and R hand pain at this time. **Have you had Surgery in the last 30 days ?** Have you had Surgery in the last 30 days ?: No **Patient Currently in Pain** Pain assessment type: Assessment Patient currently in pain: Yes Scale type: The Defense and Veterans Pain Rating Scale (DVPRS) 0-10 Pain Location: Hand Pain Description: Aching; Sharp Pain Duration: Acute Pain Goal: 0 * Pain Score: 5 * Respiratory Character (**Document RR): Normal * Level of Consciousness (POSS Scale): 1-Awake and alert **Level of Consciousness** Level of Consciousness: Alert **Glasgow Coma Scale * If coma score is persistently 5 or less, patient may be potential organ donor. Call Donor Information Referral Line per facility protocol.** Eye Opening: Spontaneous Best Verbal Response: Oriented Best Motor Response: Obeys commands Glasgow Coma Scale Score (calc): 15 **SI / HI Screening** Do You Have Thoughts Of Harming Yourself or Others?: No **Patient Info** Tetanus Shot Last Given: Unknown Dialysis Type: Not Applicable	Angelica M Lopez, RN
07:10	**Custom Formula Data**	**Other flowsheet entries** SOFA GCS: 15	Angelica M Lopez, RN
07:10	**Vital Signs(Tech)**	**Vital Signs** Temp: 98.8 °F (37.1 °C) BP: **153/91** ! MAP (Mean Arterial Pressure): 112 Pulse: 99 Resp: 16 SpO2: 97 %	Victor Martinez, Technician
07:10	**Custom Formula Data**	**Advanced Vital Signs** MAP (Mean Arterial Pressure): 112 **Other flowsheet entries** SOFA MAP: 112	Victor Martinez, Technician
07:10:14	**Provider/Patient Contact**	Tyler Aronstein, DO assigned as Attending	Tyler Aronstein, DO
07:10:14	**Assign Attending**	Attending Patient Assignment	Tyler Aronstein, DO
07:10:42	**Orders Placed**	Imaging - CT Head w/o Contrast	Tyler Aronstein, DO
07:10:43	**Rad Ordered**	CT HEAD WO CONTRAST	Tyler Aronstein, DO
07:11	**Triage Completed**		Angelica M Lopez, RN

03/31/2023 - ED in Good Samaritan Medical Center - Emergency Medicine Services - SCL Health (continued)

ED Care Timeline (continued)

07:11	**Triage Plan**	**Triage Plan** Patient Acuity: 3 Reason for Visit: Medical Triage Complete: Triage complete	Angelica M Lopez, RN
07:12:21	**Assign Nurse**	Angelica M Lopez, RN assigned as Registered Nurse	Angelica M Lopez, RN
07:12:36	**Orders Acknowledged**	New - CT Head w/o Contrast	Angelica M Lopez, RN
07:14:49	**Orders Placed**	Imaging - XR Hand Unilateral 3 Views	Tyler Aronstein, DO
07:14:52	**Rad Ordered**	XR HAND UNILATERAL 3 VIEWS	Tyler Aronstein, DO
07:16	**ED Adult Assessment**	**Assessment** Assessment Type: Initial Assessment (Complex 5+ systems) **Psychosocial WDL** Psychosocial WDL: WDL **HEENT WDL** HEENT WDL: X **HEENT Assesment** Head & Face: Other (Comment) (states mild headache) **Neurological WDL** Neurological WDL: X **Neurological Assessment** Neurological Symptoms: Headache Level of Consciousness: Alert Orientation : Oriented X4 Speech: Age appropriate; Clear Pupils Equal/React to Light : Yes Seizure: No Headache: Yes Stroke Scale Needed: No Swallow Screen (Yale) Needed: No Delirium Scale Needed: No Organ Procurement: No Additional Neuro Symptoms: No EEG Headband: No **Respiratory WDL** Respiratory WDL: WDL **Cardiovascular WDL** Cardiovascular WDL: WDL Chest Pain: No **GastroIntestinal WDL** GastroIntestinal WDL: WDL **Genitourinary WDL** Genitourinary WDL: WDL **Musculoskeletal WDL** Musculoskeletal WDL: X **Bedside Mobility Assessment Tool (BMAT)** Level 1 - Dependent: Pass Level 2 - Moderately Dependent: Pass Level 3 - Minimal Assistance Required: Pass Level 4 - Supervision or Independent: Pass **Mobility Asmt & Pt Handling Devices** Mobility Level 4 Asmt with Level 4 Devices: L4 - No assistive devices **MS / CMS Site 1** Musculoskeletal (Site #1): Right; Hand CMS / Assessment (Site #1): Intact CMS; Injury / trauma; Pain; Throbbing; Swelling Add MS Site 2: No **Integumentary WDL** Integumentary WDL: WDL	Angelica M Lopez, RN

03/31/2023 - ED in Good Samaritan Medical Center - Emergency Medicine Services - SCL Health (continued)

ED Care Timeline (continued)

07:16	**ED Plan Of Care**	**ED Plan Of Care** ED Plan Of Care Reviewed With: Patient; Family Specific Topics Reviewed: X-Ray; CT; Pain Goal and Treatment Options Referral Made: No	Angelica M Lopez, RN
07:16:15	**Orders Acknowledged**	New - XR Hand Unilateral 3 Views	Angelica M Lopez, RN
07:16:22	**Pt Ready for Rad**		Angelica M Lopez, RN
07:17:50	**Imaging Exam Started**	XR Hand Unilateral 3 Views	Leah Borszich, Technologist
07:18	**Sepsis Predictive Model Score**	**Other flowsheet entries** Early Detection of Sepsis Score: 1.59	Batch Batchqdmn
07:24:09	**Assign Nurse**	Bryony C Gorsich, RN assigned as Registered Nurse	Bryony C Gorsich, RN
07:24:09	**Remove Nurse**	Angelica M Lopez, RN removed as Registered Nurse	Bryony C Gorsich, RN
07:33	**Sepsis Predictive Model Score**	**Other flowsheet entries** Early Detection of Sepsis Score: 1.56	Batch Batchqdmn
07:38:38	**Imaging Exam Started**	CT Head w/o Contrast	Dylan S Sanders, Technologist
07:47	**Sepsis Predictive Model Score**	**Other flowsheet entries** Early Detection of Sepsis Score: 1.56	Batch Batchqdmn
07:47:05	**Imaging Exam Started**	XR Hand Unilateral 3 Views	Leah Borszich, Technologist
07:51:34	**Patient Transport In Progress**	Transport to: GS DIAGNOSTIC IMG 1	Kyle A Bladek
07:51:36	**Patient Transport In Progress**	Transport to: GS EMERG/TRAUMA SVCS ED08	Kyle A Bladek
07:51:56	**Patient Transport In Progress**	Transport to: GS EMERG/TRAUMA SVCS ED08	Kyle A Bladek
07:55:09	**Imaging Exam Started**	CT Head w/o Contrast	Dylan S Sanders, Technologist
07:55:38	**Imaging Exam Ended**	CT Head w/o Contrast	Dylan S Sanders, Technologist
07:57:20	**Imaging Exam Ended**	XR Hand Unilateral 3 Views	Leah Borszich, Technologist
07:59:06	**Order Performed**	XR Hand Unilateral 3 Views - ID: **GS11374365CR**	
08:01:15	**XR Hand Unilateral 3 Views Resulted**	Collected: **3/31/2023 07:59** Last updated: **3/31/2023 08:03** Status: **Final result**	Edi, Radiant Results In
08:01:43	**Order Performed**	CT Head w/o Contrast - ID: **GS11374523CT**	
08:03	**Sepsis Predictive Model Score**	**Other flowsheet entries** Early Detection of Sepsis Score: 1.56	Batch Batchqdmn
08:03:23	**Imaging Result**	XR Hand Unilateral 3 Views	Edi, Radiant Results In
08:03:23	**Rad Resulted**	(Final result) XR HAND UNILATERAL 3 VIEWS	Edi, Radiant Results In
08:06:19	**CT Head w/o Contrast Resulted**	Collected: **3/31/2023 08:01** Last updated: **3/31/2023 08:08** Status: **Final result**	Edi, Radiant Results In
08:08:28	**Imaging Result**	CT Head w/o Contrast	Edi, Radiant Results In
08:08:28	**Rad Resulted**	(Final result) CT HEAD WO CONTRAST	Edi, Radiant Results In

03/31/2023 - ED in Good Samaritan Medical Center - Emergency Medicine Services - SCL Health (continued)

ED Care Timeline (continued)

08:10:42	**Allergies Reviewed**		Tyler Aronstein, DO
08:11:03	**Discharge Orders Placed**	Medications - naproxen (NAPROSYN) 500 mg tablet; methocarbamoL (ROBAXIN) 500 mg tablet	Tyler Aronstein, DO
08:11:06	**Ready for Discharge**	ED Disposition set to Discharged	Tyler Aronstein, DO
08:18	**Sepsis Predictive Model Score**	**Other flowsheet entries** Early Detection of Sepsis Score: 1.56	Batch Batchqdmn
08:19	**ED Disposition**	**RN Disposition** RN Disposition: Discharge **Discharge** Discharge to: Home Procedural Sedation/Controlled Substance given : No Accompanied by: Self Discharge via: Private vehicle After Care instructions given to: Self Prescriptions Reviewed: N/A Verbalizes understanding: Yes All belongings given to: Self Date patient left unit: 03/31/23 Time patient left unit: 0819	Bryony C Gorsich, RN
08:19:25	**AVS Printed**		Bryony C Gorsich, RN
08:19:25	**ESUMM ED AVS Triggered**	Excuses ED After Visit Summary	Bryony C Gorsich, RN
08:21:11	**Disposition Task Needed**		Bryony C Gorsich, RN
08:22:18	**Registration Completed**		Suellen Lawrence
08:33	**Sepsis Predictive Model Score**	**Other flowsheet entries** Early Detection of Sepsis Score: 1.56	Batch Batchqdmn
08:47	**Sepsis Predictive Model Score**	**Other flowsheet entries** Early Detection of Sepsis Score: 1.56	Batch Batchqdmn
09:05	**Patient discharged**		Bryony C Gorsich, RN

Imaging

Imaging

XR Hand Unilateral 3 Views (Final result)

XR Hand Unilateral 3 Views — Resulted: 03/31/23 0801, Result status: Final result

Ordering provider: Tyler Aronstein, DO 03/31/23 0714
Resulted by: John Caleb Richards, MD
Performed: 03/31/23 0747 - 03/31/23 0757
Resulting lab: RADIANT

Order status: Completed
Filed by: Edi, Radiant Results In 03/31/23 0803
Accession number: GS11374365CR

Narrative:
RIGHT HAND RADIOGRAPHS
VIEWS: THREE
EXAM DATE AND TIME: 3/31/2023 7:47 MDT
INDICATION: Right hand pain. Pain in the region of the fifth metacarpal.
EPISODE OF CARE: Initial.
COMPARISON: None.

FINDINGS:

Imaging (continued)

No fracture, dislocation or osseous or soft tissue abnormality is identified in the right hand. Mineralization is normal. Articular surfaces are maintained without erosion.
IMPRESSION:
1. Negative for acute bony abnormality.
THIS DOCUMENT HAS BEEN ELECTRONICALLY SIGNED:
JOHN C. RICHARDS, MD
3/31/2023 8:01 MDT
Contributed By:

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
53 - Radiant	RADIANT	Unknown	Unknown	01/18/22 1455 - Present

CT Head w/o Contrast (Final result)

CT Head w/o Contrast Resulted: 03/31/23 0806, Result status: Final result

Ordering provider: Tyler Aronstein, DO 03/31/23 0710
Resulted by: Nathan M Coleman, MD
Performed: 03/31/23 0755 - 03/31/23 0755
Resulting lab: RADIANT
Order status: Completed
Filed by: Edi, Radiant Results In 03/31/23 0808
Accession number: GS11374523CT

Narrative:
CT HEAD WITHOUT CONTRAST
EXAM DATE AND TIME: 3/31/2023 7:55 MDT
INDICATION: Trauma.
COMPARISON: None.
TECHNIQUE: CT images of the brain were acquired in the axial plane. Dose reduction techniques were employed.
FINDINGS:
INTRACRANIAL CONTENTS:
There is no evidence of acute territorial infarct, intracranial hemorrhage, or significant intracranial mass effect.
Normal white matter for age.
There is no evidence of hydrocephalus. Mildly prominent midline posterior fossa CSF space may reflect mild anatomic variant mega cisterna magna versus small incidental arachnoid cyst.
CALVARIUM: No acute calvarial fractures.
EXTRACRANIAL STRUCTURES:
There are no acute findings of the visualized portions of the orbits or extracranial soft tissues.
IMPRESSION:
1. No evidence of acute intracranial abnormality. Specifically, no intracranial hemorrhage, mass lesion, or evidence of evolving large territorial infarct.
This study was interpreted by an ABR certified radiologist with subspecialty training in neuroradiology. Physicians or other medical providers may call 720-493-3777 with any questions.
THIS DOCUMENT HAS BEEN ELECTRONICALLY SIGNED:
NATHAN COLEMAN, MD
3/31/2023 8:06 MDT
Contributed By:

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
53 - Radiant	RADIANT	Unknown	Unknown	01/18/22 1455 - Present

03/31/2023 - ED in Good Samaritan Medical Center - Emergency Medicine Services - SCL Health (continued)

Imaging (continued)

Other Orders

Medications

naproxen (NAPROSYN) 500 mg tablet (Active)

Electronically signed by: **Tyler Aronstein, DO on 03/31/23 0811** Status: **Active**
Ordering user: Tyler Aronstein, DO 03/31/23 0811
Ordering provider: Tyler Aronstein, DO
Authorized by: Tyler Aronstein, DO
Ordering mode: Standard
Frequency: Routine Q12 03/31/23 - Until Discontinued
Class: Normal
Package: 68462-190-05

methocarbamoL (ROBAXIN) 500 mg tablet (Active)

Electronically signed by: **Tyler Aronstein, DO on 03/31/23 0811** Status: **Active**
Ordering user: Tyler Aronstein, DO 03/31/23 0811
Ordering provider: Tyler Aronstein, DO
Authorized by: Tyler Aronstein, DO
Ordering mode: Standard
PRN reasons: Muscle spasms
Frequency: Routine Q6HPRN 03/31/23 - Until Discontinued
Class: Normal
Package: 70010-754-05

03/31/2023 - ED in Good Samaritan Medical Center - Emergency Medicine Services - SCL Health Intake/Output Record

Patient Information

Patient Name	HAR	MRN	Legal Sex	DOB
Chavez, Daniel	101402087	S0619595	Male	4/29/1995

Unit

ED

Patient Demographics

Address	Phone	E-mail Address
9758 Laredo ST Unit 35D COMMERCE CITY CO 80022	720-227-6145 (Home) *Preferred*	daniel.chavez21@hotmail.com

Intake/Output

None

END OF REPORT

03/31/2023 - ED in Good Samaritan Medical Center - Emergency Medicine Services - SCL Health (continued)

After Visit Summary

Excuses (below)

Excuses

ED After Visit Summary (below)

AFTER VISIT SUMMARY

SCL Health

Daniel Chavez MRN: S0619595
3/31/2023 Good Samaritan Medical Center - Emergency Medicine Services - SCL Health 303-689-4444

Instructions

Your medications have changed today
Please talk to your MD

Read the attached information
Head Injury (Adult) (English)

Pick up these medications at SCL Health Pharmacy Services - Good Samaritan
methocarbamoL • naproxen

Address: 200 Exempla Circle, Ste. P1-142, Lafayette CO 80026, US
Hours: Mon-Fri 8:30 am -9:00 pm Sat-Sun 9:30 am - 6:00 pm
Phone: 303-689-6121

Follow up with EDWARD G KIM in 1 week (around 4/7/2023)
Contact: 10350 E DAKOTA AVE
Denver CO 80247-1314

What's Next
You currently have no upcoming appointments scheduled.

We believe in information transparency, and we believe you deserve to see your information as soon as it is available. We believe this builds trust and better relationships.

We release ALL lab & imaging results to you via MyChart as soon as they are available. Therefore, you may see some results even before we do. Please give us 2 business days to review and let you know our thoughts. We look at every result. We will contact you with any results that concern us.

If your results are not concerning, we will mail a letter, or send an online message about the results. If your results are concerning, we may reach out by phone or schedule a follow-up visit. However, if you have an immediate concern, you can send us a message or call our clinic. Otherwise, we prefer that you wait 2 business days for us to contact you or that we discuss the results at your next appointment.

Today's Visit
You were seen by Tyler Aronstein, DO

Reason for Visit
Motor Vehicle Crash

Diagnoses
- Blunt head trauma, initial encounter
- Contusion of right hand, initial encounter
- Motor vehicle collision, initial encounter

Imaging Tests
CT Head w/o Contrast
XR Hand Unilateral 3 Views

Blood Pressure 153/91	Temperature 98.8 °F
Pulse 99	Respiration 16
Oxygen Saturation 97%	

Daniel Chavez (MRN: S0619595) • Printed at 3/31/2023 8:19 AM

Page 1 of 7 Epic

Link to a trusted online description of many test results: https://medlineplus.gov/

Treatment Team

Provider	Role	Specialty	From	To
Tyler Aronstein, DO	Attending Provider	Emergency Medicine	03/31/23 0710	—

You are allergic to the following

No active allergies

Follow-up Information

Follow up With	Details	Comments	Contact Info
Edward G Kim	In 1 week		10350 E DAKOTA AVE Denver CO 80247-1314

Imaging Orders (From admission, onward)

Start		Ordered
03/31/23 0715	**XR Hand Unilateral 3 Views** 1 TIME IMAGING	03/31/23 0714
03/31/23 0711	**CT Head w/o Contrast** 1 TIME IMAGING	03/31/23 0710

Commitment to Our Patients about Antibiotics

Antibiotics only fight infections caused by bacteria. Like all drugs, they can be harmful and should only be used when necessary. Taking antibiotics when you have a virus can do more harm than good: you will still feel sick and the antibiotic could give you a skin rash, diarrhea, a yeast infection, or worse.

Antibiotics also give bacteria a chance to become more resistant to them. This can make future infections harder to treat. It means that antibiotics might not work when you really need them. Because of this, this is important that you only use an antibiotic when it is necessary to treat your illness.

How can you help? When you have a cough, sore throat, or other illness, tell your doctor you only want an antibiotic if it is really necessary. If you are not prescribed an antibiotic, ask what you can do to feel better and get relief from your symptoms.

Your health is important to us. As your healthcare providers, we promise to provide the best possible treatment for your condition. If an antibiotic is not needed we will determine a different treatment plan that will help. We are dedicated to prescribing antibiotics only when they are needed, and we will avoid giving you antibiotics when they might do more harm than good.
If you have any questions, please feel free to ask.

Adapted from CDC Get Smart: Know When Antibiotics Work

Care Everywhere Identification

If your provider participates in Care Everywhere, they may ask if you know your Care Everywhere ID. Your Care Everywhere ID for SCL Health is: EXE-WTH9-9P6V-2TPJ

Additional Information

Narcotic and Benzodiazepine Warning

While in the Emergency Department, you may have been given narcotic pain medicines (some examples: Morphine, Dilaudid, Fentanyl) or benzodiazepines (some examples: Ativan, Valium, Versed). These medicines may affect your ability to think clearly. They may also affect your ability to perform physical activities. While taking these medicines, and for 8 hours after stopping these medicines:

Do not drive.

Do not operate machinery.

Do not operate power tools.

Do not sign legal documents.

Do not supervise children by yourself.

Do not participate in activities that require climbing or being in high places.

Do not enter a body of water (lake, river, ocean, spa, swimming pool) without an adult nearby who can help you.

If you choose to participate in any of the above activities while under the influence of pain medicines or benzodiazepines, you may be at risk of physical injury, even death to yourself and others. Local laws prohibit participating in these activities while intoxicated which may result in fines, penalties, or Jail. *Colorado Revised Statutes, Title 42-4-1301*

Important Reminders Regarding Your Medication List:

- Give a list of your current medications (including prescription, over-the-counter and herbal products) to your primary care provider as well as any other healthcare providers you see.
- Carry a list of your medications (prescription, over-the-counter and herbal products) with you at all times. Update the list when medications are discontinued, doses are changed, or new medications are added.
- The instructions on your medication bottle(s) may be different from these instructions. If you do not understand when or how to take your medications or why you are taking them, please talk to your provider or pharmacist before you take the medication.
- Some foods and herbal products can interact with medications. Consult your provider or pharmacist if you plan to begin taking supplements or herbals.

Your Medication List

START **methocarbamoL** 500 mg tablet Commonly known as: ROBAXIN	Take 1 tablet (500 mg) by mouth every six hours, as needed for Muscle spasms
START **naproxen** 500 mg tablet Commonly known as: NAPROSYN	Take 1 tablet (500 mg) by mouth in the morning and 1 tablet (500 mg) before bedtime.

MyChart
March 31, 2023

Dear Daniel:

Thank you for enrolling in MyChart. MyChart allows you to view your test results, medications, allergies, and more.

Please follow the instructions below to securely access your online medical record.

How Do I Sign Up?

1. In your Internet browser, go to https://mychart.sclhealth.org/.
2. Click on the **Sign Up Now** link in the New User box. You will see the New Member Sign Up page.
3. Enter your MyChart Activation Code exactly as it appears below. You will not need to use this code after you've completed the sign-up process. NOTE: If you do not activate your MyChart account before the expiration date, you must request a new code by visiting your clinic or hospital at which you have been a recent patient and provide proper identification.

MyChart Activation Code: 5GN8V-T4BB7-XT9KE
Expires: 5/10/2023 8:19 AM

4. Enter your Date of Birth (mm/dd/yyyy), residential Zip Code and click **Submit**.
5. Create a MyChart Username. This will be your MyChart login ID and cannot be changed. Think of one that is secure and easy to remember.
6. Create a MyChart Password. You can change your password at any time.
7. Choose a Security Question and Answer, and click **Next**. The Security Question and Answer can be used to access MyChart if you forget your password.
8. Enter your e-mail address. You will receive e-mail notification when new information is available in MyChart.
9. Click **Sign In**. You can now view your medical record.

Additional Information

If you have questions, please call 855-274-2517 to talk with our MyChart staff. Remember, MyChart is NOT to be used for urgent needs. For medical emergencies, dial **911**.

Sincerely,

MyChart Team

Attached Information — Head Injury (Adult) (English)

Head Injury (Adult)

You have a head injury. It doesn't appear serious at this time. But symptoms of a more serious problem, such as a mild brain injury (concussion) or bruising or bleeding in the brain, may appear later. For this reason, you or someone caring for you will need to watch for the symptoms listed below. Once you're home, also be sure to follow any care directions you're given.

Home care

Watch for the following symptoms

Seek emergency medical care if you have any of these symptoms over the next hours to days:

- Headache that gets worse or doesn't go away
- Nausea or vomiting
- Dizziness
- Sensitivity to light or noise
- Unusual sleepiness or grogginess
- Trouble falling asleep
- Personality changes
- Vision changes
- Memory loss
- Confusion
- Trouble walking or clumsiness
- Loss of consciousness (even for a short time)
- Inability to be awakened
- Stiff neck
- Weakness or numbness in any part of the body
- Seizures

General care

- If you were prescribed medicines for pain, use them as directed. Note: Don't take other medicines for pain without talking to your healthcare provider first.
- To help reduce swelling and pain, apply a cold source to the injured area for up to 20 minutes at a time. Do this as often as directed. Use a cold pack or bag of ice wrapped in a thin towel. Never apply a cold source directly to the skin.
- If you are on a blood thinner for a health condition and have a head injury, follow your healthcare provider's specific directions. You are at a higher risk for bleeding from the blood thinner, so your provider will talk to you about taking extra precautions.
- If you have cuts or scrapes as a result of your head injury, care for them as directed.
- For the next 24 hours (or longer, if directed):
  - Don't drink alcohol or use sedatives or other medicines that make you sleepy.
  - Don't drive or operate machinery.
  - Don't do anything strenuous, such as heavy lifting or straining.
  - Limit tasks that need concentration. This includes reading, using a smartphone or computer, watching TV, and playing video games.

- Don't return to sports or other activities that could result in another head injury until approved by your healthcare provider.

Follow-up care

Follow up with your healthcare provider, or as directed. If imaging tests were done, they will be reviewed by a healthcare provider. You will be told the results and any new findings that may affect your care.

When to seek medical advice

Call your healthcare provider right away if any of the following occur:

- Pain doesn't get better or gets worse
- New or increased swelling or bruising
- Increased redness, warmth, drainage, or bleeding from the injured area
- Fluid drainage or bleeding from the nose or ears
- Any depression or bony abnormality in the injured area
- Persistent confusion or lethargy
- Personality changes
- Bruising behind the ears or bruising around the eyes

StayWell last reviewed this educational content on 12/1/2022

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Documents

Admission Record

Scan on 3/31/2023 8:00 AM

Scan (below)

Documents (continued)

Valuables, Patient Rights & Responsibilities, Notice of Privacy Practices

1. VALUABLES/PERSONAL PROPERTY

I understand and acknowledge that this facility or clinic will not be liable for the loss or damage of any money, jewelry, glasses, hearing aids, dentures, prosthetic devices, documents, garments, or other articles, regardless of the article's value or size, unless such article is formally transferred to the care, custody and control of the applicable facility or clinic as evidenced by issuance of a receipt. Without such receipt this facility or clinic shall not be liable for any loss or damage of any personal property. State or other law may limit the liability for loss of any personal property unless a written receipt has been obtained by me from the SCL Health facility.

2. PATIENT RIGHTS & RESPONSIBILITIES

A copy of Patient Rights and Responsibilities has been offered to me. I may also find a copy of Patient Rights and Responsibilities posted throughout the facilities, on the sclhealth.org website, or I may request a paper copy. I understand that I have the right and obligation to express any concerns about my care and treatment to a Management Representative.

3. NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the Notice of Privacy Practices (NPP) in effect for the SCL Health arrangement, as stated in the NPP. For explanation of additional use and disclosure of my medical records in the course of receiving services, I may refer to the SCL Health Notice of Privacy Practices.

Select the person signing the form ✓ Signature complete!

☐ Verbal Consent

☐

Patient ☑ CHAVEZ , DANIEL

Other ☐

Relationship to Patient: Self

Reason Patient Unable to Sign: --

Patient or Authorized Representative Signature
Electronically signed on 03/31/2023, 7:59 AM

2nd Witness Signature
Witness: Electronically witnessed by:
Lawrence, Suellen: S061526
03/31/2023 07:59:28 am

SCL Health
GOOD SAMARITAN
Valuables, Patient Rights & Responsibilities, Notice of Privacy Practices
EH-FR-TX-3844-0821-SCLHS

S0619595 Emergency 251505512
CHAVEZ , DANIEL
27 y 4/29/1995 M ADM: 3/31/2023
ARONSTEIN, TYLER

Ambulance Record

Scan on 3/31/2023 6:32 PM

Scan (below)

03/31/2023 - ED in Good Samaritan Medical Center - Emergency Medicine Services - SCL Health (continued)

Documents (continued)

Thornton Fire Department
Patient Care Record

Name: CHAVEZ, DANIEL **Incident #:** 23004354 **Date:** 03/31/2023 Patient 1 of 2

Patient Information			
Last	CHAVEZ	**Address**	9750 Laredo st
First	DANIEL	**Address 2**	35D
Middle		**City**	Commerce City
Gender	Male	**State**	CO
DOB	04/29/1995	**Zip**	80022
Age	27 Yrs, 11 Months, 2 Days	**Country**	US
Weight	220.0lbs - 99.8kg	**Tel**	
Pedi Color		**Physician**	
SSN		**Ethnicity**	Hispanic or Latino
Race	Hispanic or Latino		
Advance Directives			
Resident Status			
Patient Resides in Service Area			
Temporary Residence Type			

Clinical Impression			
Primary Impression	Injury		
Secondary Impression			
Protocols Used			
Local Protocol Provided Care Level			
Anatomic Position			
Onset Time			
Last Known Well			
Chief Complaint	Hand injury		
Duration		**Units**	
Secondary Complaint			
Duration		**Units**	
Patient's Level of Distress			
Signs & Symptoms	Injuries - Injury to hand		
Injury	Motorized Vehicle Accident - Auto traffic accident injures occupant - Street or Highway - 03/31/2023		
Additional Injury			
Mechanism of Injury	Blunt		
Medical/Trauma	Trauma		
Barriers of Care	None Noted		
Alcohol/Drugs	None Reported		
Pregnancy			
Initial Patient Acuity			
Final Patient Acuity			
Patient Activity			

Medications/Allergies/History/Immunizations	
Medications	Metformin
Allergies	No known allergies
History	Other - Prediabetes
Immunizations	
Last Oral Intake	

Vital Signs

Time	AVPU	Side	POS	BP	Pulse	RR	SPO2	ETCO2	CO	BG	Temp	Pain	GCS(E+V+M)/Qualifier	RTS	PTS
06:35	Alert	R	Sit	154/94 A	110 R	22 R		pc				4	15= 4 + 5 + 6 /NQ	12	
06:49				162/70 A	112 R	18 R	94 Rm	pc				5	15= 4 + 5 + 6 /NQ	12	

Narrative

DISPATCH/RESPONSE:
E76/M73 dispatched by a 911 system to an intersection for a reported two vehicle MVA and responded immediately.

ARRIVAL:
Two vehicle MVA. Four door sedan presented with moderate to heavy front end damage. The vehicle was reported to be traveling approx 45mph at time of wreck. Airbags were deployed; all parties restrained with no LOC.

Upon arrival, found E76 paramedic attending a 27 year old male patient in the driver side of vehicle. The patient stated he'd like he and his daughter transported and assessed at the hospital. The patient admitted his left hand hurting ("4") and striking the side of his head against the frame of the vehicle in vicinity of the b post; hand was the primary complaint.

The patient was able to ambulate to Med73 without complication. The patient sat on the bench seat during transportation due to daughter being on the stretcher and for him to be nearby her. Patient was reassessed multiple times during transport within only minor increase concerning his hand pain. The patient also denied pain medication whenever offered.

The patient denied change in vision, shortness of breath, diarrhea, chest pain, ABD pain, neck pain, back pain, numbness or tingling in extremities, ETOH, drugs, recent trauma or illness.

ASSESSMENT: Narrative Assessment supersedes ESO Assessment

Hospital Chart Number: 251505512 *Page 1 of 6*

03/31/2023 18:23:10
PCRID: 58c92022-c60b-4695-9dab-afd6006adada
Electronically Signed by: Kennedy, James
Template Version: PCR-EXTRACT-1.3.1
Data Version: AAAAAAyXIVQ=

03/31/2023 - ED in Good Samaritan Medical Center - Emergency Medicine Services - SCL Health (continued)

Documents (continued)

Thornton Fire Department
Patient Care Record

Name: CHAVEZ, DANIEL **Incident #:** 23004354 **Date:** 03/31/2023 Patient 1 of 2

Narrative

Mental Status: Alert and oriented x4/4 (Person, Place, Time & Event) / GCS 15. Cooperative
Speech: Clear speech. Able to answer all questions appropriately.
Skin: Pink, warm, and dry. Cap refill <2 sec.
HEENT: Unremarkable
Head: Clear of apparent trauma; reports minor headache left side.
Ears: No visual signs of trauma.
Eyes: Pupils are PERRL.
Nose: No visual signs of trauma.
Throat and Neck: Not assessed. Negative JVD. Clear of apparent trauma
Chest: Chest wall is intact with no signs of trauma, flail chest, and/or crepitus on palpation.
Respirations: Non-labored respirations.
Lung Sounds: not assessed
Abdomen:not assessed
CTLS: Clear of deformities and is non-tender upon palpation.
Back: Clear of deformities and is non-tender upon palpation.
Pelvis: Intact and stable
Extremities: Left hand pain at knuckles 3 and 4 with no deformity; otherwise, unremarkable in all extremities.
Neurologic: Unremarkable, PMSx4.

TREATMENT:
Vital signs, physical exam.

The patient did not receive C-Collar due to not meeting Nexus or Canadian Criteria except for nature of MVA. Patient denied any midline throughout transport.

Patient denied pain medication.

TRANSPORT:
The patient ambulated to Med73 and sat in a position of comfort. Patient was transported to the hospital on the stretcher. Pt was transported for treatment and evaluation to NSMC ED. Patient care was transferred to receiving hospital staff.
All times approximate.

Kennedy JA 9463
NRP

Patient's tablet was left in M73. The patient was contacted on M73 phone and informed we still had it. He later met me at Station 73 to have tablet returned to him.

Specialty Patient - Outbreak Screening

Outbreak Screened	COVID-19		
Onset of Signs/Symptoms			
Symptoms Reported	None		
Has the patient traveled outside the community in the past 30 days?			
No			
Travel Start Date		**Travel End Date**	
Travel Locations			
Has the patient traveled outside the United States in the past 30 days?			
No			
Travel Start Date		**Travel End Date**	
Travel Locations			
Has the patient had household or close contact w/ someone with above symptoms and travel history?			No
Has the patient had household or close contact w/ someone with confirmed diagnosis of illness being screened?			No
Comments			

Incident Details		Destination Details		Incident Times	
Location Type	Street or Highway	**Disposition**		**PSAP Call**	
Location		**Unit Disposition**	Patient Contact Made	**Dispatch Notified**	
Address	128th Ave and holly st	**Patient Evaluation and/or Care Disposition**	Patient Evaluated and Care Provided	**Call Received**	06:10:05
Address 2		**Crew Disposition**	Initiated and Continued Primary Care	**Dispatched**	06:10:23
Mile Marker		**Transport Disposition**	Transport by This EMS Unit (This Crew Only)	**En Route**	06:12:44
City	Thornton	**Reason for Refusal or Release**		**Staged**	
County	Adams	**Transport Mode Descriptors**	No Lights or Sirens	**Resp on Scene**	06:16:12
State	CO	**Transport Due To**	Protocol	**On Scene**	06:17:49
Zip	80602	**Transported To**	Good Samaritan Med Cntr (HDE)	**At Patient**	06:17:55

Hospital Chart Number: 251505512 *Page 2 of 6*

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03/31/2023 - ED in Good Samaritan Medical Center - Emergency Medicine Services - SCL Health (continued)

Documents (continued)

Thornton Fire Department
Patient Care Record

Name: CHAVEZ, DANIEL **Incident #:** 23004354 **Date:** 03/31/2023 Patient 1 of 2

Incident Details		Destination Details		Incident Times	
Country	US	**Requested By**	Bystander	**Care Transferred**	
Medic Unit	MED73	**Destination**	Hospital	**Depart Scene**	06:36:07
Medic Vehicle	FD7028	**Department**	Emergency Room	**At Destination**	07:17:22
Run Type	Emergency Response (Primary Response Area)	**Address**	200 Exempla Circle	**Pt. Transferred**	
Response Mode	Emergent	**Address 2**		**Call Closed**	07:27:34
Response Mode Descriptors	Lights and Sirens	**City**	Lafayette	**In District**	
Shift	B Shift	**County**	Boulder	**At Landing Area**	
Zone	70801	**State**	Colorado		
Level of Service	Advanced Life Support	**Zip**	80026		
EMD Complaint	Traffic Accident	**Country**	US		
EMD Card Number		**Zone**	T1		
Dispatch Priority		**Condition at Destination**	Unchanged		
		State Wristband #			
		Destination Record #			
		Trauma Registry ID			
Alternative Disposition Offered	Alternative disposition not offered to patient				

Crew Members

Personnel	Role	Certification Level
Kennedy, James	Lead	EMT-Paramedic - Q150097
FREEMAN, BEN	Driver	EMT-Basic - Q190835
Morrison, Donald	Other	EMT-Basic - 13251; EMT-Basic - 13251
Lybarger, Joshua	Other	EMT-Basic - 040430; EMT-Basic - 040430
ENGLE, GREG	Other	EMT-Paramedic - Q172486

Insurance Details

Insured's Name		**Primary Payer**	Insurance	**Dispatch Nature**	
Relationship		**Medicare**		**Response Urgency**	
Insured SSN		**Medicaid**		**Job Related Injury**	
Insured DOB		**Primary Insurance**	Kaiser	**Employer**	
Address1		**Policy #**		**Contact**	
Address2		**Primary Insurance Group Name**		**Phone**	
Address3		**Group #**		**Mileage to Closest Hospital**	
City		**Secondary Ins**			
State		**Policy #**			
Zip		**Secondary Insurance Group Name**			
Country	US	**Group #**			

Mileage			Delays		Additional Agencies
Scene	1.0		**Category**	**Delays**	Thornton Police Department
Destination	14.9		Dispatch Delays	None/No Delay	
Loaded Miles	13.9	geo-verified	Response Delays	None/No Delay	
Start			Scene Delays	Other (Not Listed)	
End			Transport Delays	None/No Delay	
Total Miles			Turn Around Delays	None/No Delay	

Next of Kin

Next of Kin Name		**Address1**		**City**	
Relationship to Patient		**Address2**		**State**	
Phone		**Address3**		**Zip**	
				Country	US

Patient Transport Details

How was Patient Moved to Ambulance		**How was Patient Moved From Ambulance**	
Patient Position During Transport	Sitting	**Condition of Patient at Destination**	Unchanged

Hospital Chart Number: 251505512 *Page 3 of 6*

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03/31/2023 - ED in Good Samaritan Medical Center - Emergency Medicine Services - SCL Health (continued)

Documents (continued)

Thornton Fire Department
Patient Care Record

Name: CHAVEZ, DANIEL **Incident #:** 23004354 **Date:** 03/31/2023 Patient 1 of 2

Billing Authorization

Authorization	TFD Authorizaton Form

Section I - Patient / Parent of Minor Authorization Signature

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for services provided to me by Thornton Fire Department (Thornton Fire) now, in the past, or in the future, until such time as I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by Thornton Fire, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to Thornton Fire any payments that I receive directly from insurance or any other source whatsoever for the services provided to me and I assign all rights to such payments to Thornton Fire. I authorize Thornton Fire to appeal payment denials or other adverse decisions on my behalf. I authorize and direct any holder of medical, insurance, billing or other relevant information about me to release such information to Thornton Fire and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by Thornton Fire, now, in the past, or in the future. I also authorize Thornton Fire to obtain medical, insurance, and billing and other relevant information about me from any party, database or other source that maintains such information.

Signature

Signed On	03/31/2023 06:55:35
Notice of Privacy Practices Provided	Yes
Billing Authorization	Agree
HIPAA Acknowledgement	Agree

Section II - Authorized Representative Signature

Complete this section only if the patient is physically or mentally unable to sign.
Authorized representatives include only the following:(Check one)

- ☐ Patient's Legal Guardian
- ☐ Patient's Medical Power of Attorney
- ☐ Relative or other person who receives benefits on behalf of the patient
- ☐ Relative or other person who arranges treatment or handles the patient's affairs
- ☐ Representative of an agency or institution that provided care, services or assistance to patient

I am signing on behalf of the patient to authorize the submission of a claim for payment to Medicare, Medicaid, or any other payer for any services provided to the patient by the transporting ambulance service now or in the past or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. **My signature is not an acceptance of financial responsibility for the services rendered.**

Signature

Signed On	
Printed Name	
Reason unable to sign	

Hospital Chart Number: 251505512 *Page 4 of 6*

03/31/2023 18:23:10
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03/31/2023 - ED in Good Samaritan Medical Center - Emergency Medicine Services - SCL Health (continued)

Documents (continued)

Thornton Fire Department
Patient Care Record

Name: CHAVEZ, DANIEL **Incident #:** 23004354 **Date:** 03/31/2023 Patient 1 of 2

Section III - EMS Personnel and Facility Signatures

Complete this section if the patient was mentally or physically incapable of signing, and no Authorized Representative (section II) was available or willing to sign on behalf of the patient at the time of service.

EMS Personnel Signature

My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf. **My signature is not an acceptance of financial responsibility for the services rendered.**

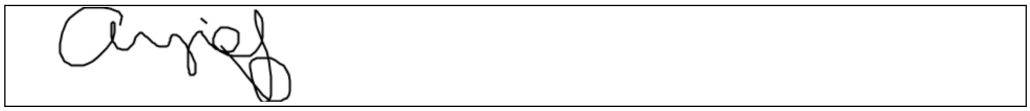
Signed On	
Printed Name	
Reason unable to sign	

Facility Representative Signature

The patient named on this form was received by this facility on the date and at the time indicated and this facility furnished care, services or assistance to the patient. **My signature is not an acceptance of financial responsibility for the services rendered.**.

Signed On	
Printed Name	
Title of Representative	

Facility Signatures



Signed On	03/31/2023 07:05:56
Receiving	Angie rn

Signed On	
Paperwork Received	

Signed On	
Airway Confirmation	

Hospital Chart Number: 251505512 *Page 5 of 6*

03/31/2023 18:23:10
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03/31/2023 - ED in Good Samaritan Medical Center - Emergency Medicine Services - SCL Health (continued)

Documents (continued)

Thornton Fire Department
Patient Care Record

Name: CHAVEZ, DANIEL **Incident #:** 23004354 **Date:** 03/31/2023 Patient 1 of 2

Provider Signatures

Lead Provider	Kennedy, James	**Certification Level**	EMT-Paramedic - Q150097
Provider	FREEMAN, BEN	**Certification Level**	EMT-Basic - Q190835
Provider		**Certification Level**	
Provider		**Certification Level**	

Hospital Chart Number: 251505512 *Page 6 of 6*

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Consent Forms

Scan on 3/31/2023 8:00 AM

Scan (below)

03/31/2023 - ED in Good Samaritan Medical Center - Emergency Medicine Services - SCL Health (continued)

Documents (continued)

AGREEMENT FOR TREATMENT, EXAMINATION, AND ADMISSION

DEFINITIONS: All references in this consent form to "SCL Health" shall mean Sisters of Charity of Leavenworth Health System, Inc. and any and all of its controlled affiliates, including but not limited to its hospitals and clinics.

AGREEMENT FOR MEDICAL EXAMINATION - TREATMENT CONSENT, REPORTING REQUIREMENTS OF CERTAIN MEDICAL CONDITIONS AND INDEPENDENT CONTRACTOR STATUS OF SOME HEALTHCARE PROVIDERS.

This "Agreement for Medical Examination - Treatment Consent, Reporting Requirement for Certain Medical Conditions and Independent Contractor Status of Some Healthcare Providers" section gives SCL Health and affiliated Clinicians permission to perform medical treatments, procedures, examinations and tests on you as explained below:

- I understand that my care is under the supervision and control of my attending/treating physician(s) and/or health care providers such as Physician Assistants or Nurse Practitioners (collectively "Clinicians"), as allowed by law.
- I give permission for all medical treatments, procedures, examinations including X-Ray/medical imaging, administration of drugs, and/or any other diagnostic or therapeutic tests reasonably necessary for my proper care, including HIV testing. I understand that all of these procedures and/or tests may be done on an inpatient, observation or outpatient basis while I am in the hospital and on an outpatient basis after my discharge from the hospital or as a clinic patient without regard to any hospital status. My permission is given for continued procedures and tests on a recurring or on an as needed/as individually ordered basis. I understand that I have the right to more complete information concerning any particular diagnostic or therapeutic procedure and I may be asked for a more specific consent (verbal or written) to such procedures.
- I understand and agree that there may be circumstances under which the Clinician(s) or the hospital/health care facility is required to report to outside third parties such as health departments or the Center for Disease Control and Prevention (CDC) information pertaining to communicable diseases such as HIV, TB, and viral meningitis. I understand that disclosure of my Federal Social Security Number in reference to Medical Devices is required by the FDA under the Safe Medical Devices Act of 1990 and also for other state and federally mandated requests.
- I give permission that aspects of my care and treatment may be recorded and/or filmed for internal SCL Health purposes, such as medical/nursing student education or for quality purposes.
- I understand that no person has the authority to alter or amend this paragraph or any other paragraph in any manner.
- I give permission to the disposal by SCL Health of any tissues or parts which may be removed in the course of any procedure performed upon me. Body fluid exposures will be managed according to the laws of the state in which the SCL Health facility is located or by other applicable law.
- If I am pregnant I also give permission for testing and treatment of my unborn child and my newborn infant – all of this form applies equally to me, my unborn child, and my newborn infant.

I recognize and understand that all Clinicians furnishing services to me, including, but not limited to, my attending physicians, other physicians holding clinical privileges at this facility or clinic, and other physicians such as those providing services to me in anesthesiology, radiology, pathology and emergency medicine, may be independent contractors and are not the employees or agents of SCL HEALTH or of each other while providing professional services. I am signing this form with the understanding that SCL HEALTH and the Clinicians are providing services to me in express reliance on this written statement/my signature.

CERTIFICATION OF AGREEMENT TO BE BOUND BY THIS AGREEMENT

I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULT OF TREATMENT OR SERVICES PROVIDED OR TO BE PROVIDED TO ME. I CERTIFY THAT I HAVE READ THE ABOVE AGREEMENT (OR IT HAS BEEN READ TO ME) AND I UNDERSTAND WHAT IT SAYS. MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I HAVE BEEN OFFERED A COPY OF THIS DOCUMENT. I CERTIFY THAT I AM THE PATIENT OR PERSON DULY AUTHORIZED BY THE PATIENT TO EXECUTE THIS AGREEMENT AND I AGREE TO ITS TERMS.

Select the person signing the form ✓ Signature complete!

☐ Verbal Consent

☐

Patient ☑ CHAVEZ , DANIEL

Other ☐

Relationship to Patient: Self

Reason Patient Unable to Sign: --

Patient or Authorized Representative Signature
Electronically signed on 03/31/2023, 7:59 AM

2nd Witness Signature
Witness: Electronically witnessed by:
Lawrence, Suellen: S061526
03/31/2023 07:59:10 am

SCL Health
GOOD SAMARITAN
Agreement For Treatment, Examination, and Admission
EH-FR-TX-0678-1117-SCLHS

S0619595 Emergency 251505512
CHAVEZ , DANIEL
27 y 4/29/1995 M ADM: 3/31/2023
ARONSTEIN, TYLER

Facesheet/Demographics

Scan on 3/31/2023 9:55 AM

Scan (below)

03/31/2023 - ED in Good Samaritan Medical Center - Emergency Medicine Services - SCL Health (continued)

Documents (continued)

PATIENT INFO

MED REC #	ROOM/BED	CSN	ICD CODE	ADMIT DATE/TIME	PATIENT CLASS
S0619595	ED08 ED08	**251505512**		3/31/2023 0705	Emergency

SERV/LOC	BIRTHDATE	AGE	SEX	MARITAL STATUS	FINANCIAL CLASS
ED	4/29/1995	27yr	M	Married	Commercial

PATIENT NAME AND ADDRESS
CHAVEZ, DANIEL
9758 LAREDO ST UNIT 35D
COMMERCE CITY, CO 80022

SSN	DISCHARGE DATE	MOM'S #
xxx-xx-0001	3/31/2023	

ADM CLERK	ACCOM	ADMISSION SOURCE
LAWRENCE,	Med/Surg/Gyn	Non Health Care Facility*

ARRIVAL MODE	RELIGION
Ambulance	Jehovah's Witness

VISIT REASON
MOTOR VEHICLE CRASH

HOME PHONE: 720-227-6145
OTHER PHONE:
PATIENT E-MAIL: daniel.chavez21@hotmail.com

EMPLOYER: CO UNKNOWN
OCCUPATION:
EMP PHONE:
EMPLOYER ADDRESS: CO UNKNOWN

MD INFO

PRIMARY CARE PHYSICIAN	PCP PHONE	REFERRING PHYSICIAN
KIM, EDWARD G (GENERAL)	None	
ATTENDING/ER PHYSICIAN	**ATT PHONE**	**REFERRING PHONE**
ARONSTEIN, TYLER	303-425-2087	
ADMITTING PHYSICIAN	**ADM PHONE**	

EMERG CONTACT

CONTACT #1	RELATIONSHIP	CONTACT #1 PHONE	CONTACT #1 WORK PHONE

CONTACT #1 ADDRESS

CONTACT #2
CONTACT #2 PHONE
CONTACT #2 WORK PHONE

GUARANTOR

GUARANTOR NAME AND ADDRESS
CHAVEZ,DANIEL
9758 LAREDO ST UNIT 35D
COMMERCE CITY, CO 80022

GUAR PHONE: 720-227-6145
GUARANTOR EMPLOYER: CO UNKNOWN
GUAR EMPLOYER PHONE:
GUARANTOR SSN: xxx-xx-0001
RELATIONSHIP: Self

INS #1

INSURANCE NAME	INSURANCE PHONE	POLICY #	GROUP #
AUTO THIRD PARTY LIABILITY - AUTO	877-930-5606	AUTO12345	
INSURANCE PLAN ADDRESS	**INSURANCE PLAN NAME**	**SUB DOB**	**AUTHORIZATION #**
CONTINUUM PO BOX 173610 DENVER, CO 80217	AUTO INSURANCE	04/29/1995	
	SUBSCRIBER		**SUB SSN**
	CHAVEZ,DANIEL		xxx-xx- 0001

INS #2

INSURANCE NAME	INSURANCE PHONE	POLICY #	GROUP #
KAISER PERM HMO - KAISER PERMANENTE	303-338-3800	435115225	36437053
INSURANCE PLAN ADDRESS	**INSURANCE PLAN NAME**	**SUB DOB**	**AUTHORIZATION #**
PO BOX 373150 CLAIMS DEPT DENVER, CO 80237-3150	KAISER	04/29/1995	
	SUBSCRIBER		**SUB SSN**
	CHAVEZ,DANIEL		xxx-xx- 0001

MD NOTES (OPTIONAL)

FINAL DIAGNOSIS: _____
OPERATIONS/PROCEDURES: _____
_____
CONSULTANTS: _____
DATE: _____ ATTENDING PHYSICIAN: _____

HIM

	DATE	INITIALS
DISCHARGE		
PICKED UP		
SCANNED		
CA REG		
ASSEMBLED		
ANALYZED		
COMPLETE		

SCL Health
Good Samaritan Medical Center

S0619595
03/31/23

PATIENT INFORMATION
S0619595 Emergency **251505512**
CHAVEZ, DANIEL
4/29/1995 (27 yrs) M ADM: 3/31/2023
ARONSTEIN, TYLER

Payment/Ins/Billing Info

Scan on 3/31/2023 8:00 AM

Scan (below)

AGREEMENT FOR ASSIGNMENT OF INSURANCE BENEFITS

DEFINITIONS: All references in this consent form to "SCL Health" shall mean Sisters of Charity of Leavenworth Health System, Inc. and any and all of its controlled affiliates, including but not limited to its hospitals and clinics.

SECTION 1. ASSIGNMENT OF INSURANCE BENEFITS

This "Assignment of Insurance Benefits" allows SCL Health to bill your insurance company and for your insurance company to pay SCL Health as explained below: I for myself or for the patient (referred to as "I" or "Patient" or "me" or "my") give my permission for my insurance company(ies) to make payment directly to SCL HEALTH of inpatient and outpatient hospital and/or clinic services and related benefits, including major medical, otherwise payable to me. I certify that information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is true and correct to the best of my knowledge. I irrevocably assign to SCL HEALTH all right, title and interest in compensation or payment received or to be received from any source as a result of injuries sustained by me, and any person or corporation having notice of this assignment is hereby authorized and directed to pay directly to SCL HEALTH the amount of any indebtedness due SCL HEALTH for services provided by them to me. Additionally, I understand and agree that each Clinical group, to include certain SCL Health affiliates, or individual health care providers/practitioner thereof (referred to as the "Clinicians" or "health care providers") who provide professional services to me will bill and collect for their own professional services separate and apart from SCL HEALTH facility charges, but subject to the authorizations granted by me in accordance with this agreement, and I hereby authorize and request that insurance benefits for medical and professional services, otherwise payable to me, be assigned and paid directly to the Clinicians who rendered care to me. In the case of Medicare benefits, payment may not exceed the maximum allowable charge as determined by the Medicare carrier.

SECTION 2. STATEMENT OF FINANCIAL RESPONSIBILITY/TRANSFER OF CREDITS

This "Statement of Financial Responsibility/Transfer of Credits" is your promise to pay for any services not covered by your insurance company as explained below: I understand the services provided by SCL HEALTH and/or the Clinicians, today or in the future, may or may not be paid for by my health plan or health insurance. If my health plan/insurance deems any or all of these services are not covered and/or not medically necessary for any reason, then I understand that I am personally financially responsible for payment of those services and/or supplies provided to me and I agree to be the guarantor of payment for all services rendered to me in accordance with the regular charges and terms of SCL HEALTH and the Clinicians for such services. If this agreement is executed by a spouse or a financial guarantor of the Patient, the spouse or the financial guarantor shall be jointly and severally liable with me (meaning that both I and my spouse or financial guarantor will be obligated to pay the Clinicians and SCL HEALTH), and by me or my personal representative signing this agreement, those persons, together with me, do hereby promise to pay the Clinicians and SCL HEALTH all amounts due and owing for my account. Although the Clinicians and/or SCL HEALTH may file insurance claims as a courtesy, I understand that the Clinicians and/or SCL HEALTH cannot accept responsibility for collecting insurance payments or for negotiating a disputed claim, unless a contractual or legal obligation of the Clinicians and/or SCL HEALTH provides otherwise. Insurance reimbursement is a contract between me and my insurance carrier and an insurance company's Usual, Customary and Reasonable ("UCR") allowables or fee schedules are generally established without regard to the Clinicians' or SCL HEALTH' charges except in circumstances where the Clinicians and/or SCL HEALTH have a contractual agreement(s) with a health plan that prohibits such collection of payment from me and/or the subscriber. Should this account be referred to an attorney or collection agency, reasonable attorney's fees and/or collection expenses shall be payable by me in addition to any other amounts due. I hereby authorize the transfer of monies paid to SCL HEALTH by me or on my behalf and otherwise refundable to me, to be transferred to settle any indebtedness I owe to SCL HEALTH, for which I am responsible.

Continued on next page

SECTION 3. PERMISSION TO BE CONTACTED BY DIFFERENT METHODS TO INCLUDE MY CELL PHONE

This "Permission to be Contacted by Different Methods to Include My Cell Phone" allows SCL Health to contact me and how it will contact me as explained below: By signing below and as part of my admission, treatment, evaluation, diagnosis, prescriptions, testing and/or lab results ("Services"), "), I expressly understand, consent and agree that SCL HEALTH and its hospitals/clinics, affiliated physician groups, as well as any and all of their affiliates, sub-contractors, agents, labs, vendors, assigns, representatives, successors and debt collectors ("the Calling Parties") may call or contact me for any reason related to the provision of the above Services using an automatic telephone dialing systems, predictive dialer, artificial or prerecorded voice and/or prerecorded messages, via any electronic mail addresses through individual or automatically generated electronic mail, and via text messaging through individual and automatically generated text messages at (a) any cellular telephone number or land-line number or electronic mail address that I or any person acting on my behalf may provide to the Calling Parties at the time of, during, or after any hospital/clinic admission, follow up visit, telephone call, payment or address update, or (b) at any telephone number the Calling Parties can find me at in the future as a result of skip-tracing, call capture, caller ID technology, internet search engines, White Pages and/or similar search methods. This consent applies to all healthcare providers covered under this agreement. If I wish to revoke consent to call my cell phone, I agree to provide you notice of that revocation by emailing you at Donotcall@sclhealth.org, mailing it to SCL Health, Attn: Do Not Call-Self Pay, 500 Eldorado Blvd., Broomfield, CO 80021 or calling the toll free line at 1-866-665-2636. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto-dialer technology and/or prerecorded messages.

I AGREE TO BE BOUND BY SECTIONS 1, 2, AND 3.

Select the person signing the form ✓ Signature complete!

☐ Verbal Consent

☐

Patient ☑ CHAVEZ , DANIEL

Other ☐

Relationship to Patient: Self

Reason Patient Unable to Sign: --

Patient or Authorized Representative Signature
Electronically signed on 03/31/2023, 7:59 AM

2nd Witness Signature
Witness: Electronically witnessed by:
Lawrence, Suellen: S061526
03/31/2023 07:59:19 am

SCL Health
GOOD SAMARITAN
Agreement for Assignment of Insurance Benefits
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EH-FR-TX-0679-0819-SCLHS

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CHAVEZ , DANIEL
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ARONSTEIN, TYLER

Scan on 3/31/2023 8:00 AM

Scan (below)

Patient Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "Balance Billing" (sometimes called "Surprise Billing")?

When you see a doctor or health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a healthcare facility that is not in your health plan's network.

"Out-of-network" describes providers and facilities that have not signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called **"balance billing"**. This amount is likely higher than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care, for example, when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from Balance Billing for:

1. **Emergency services**
   If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **cannot** be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

2. **Certain services at an in-network hospital or ambulatory surgical center**
   When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensives services. These providers **cannot** balance bill you and may **not** ask you to give up your protections not to be balance billed.

   If you get other services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

   You are <u>never required</u> to give up your protection from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

Continued on next page

3. Additional protections under Colorado State Law (applicable to Colorado-Based Health Plans only):

- Your insurer will pay out-of-network providers and facilities directly. You are only responsible for paying your in-network cost-sharing for covered services.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.
- Your provider or facility or agency must refund any amount you overpay within 60 days of being notified.
- Provider, hospital, or outpatient surgical facility cannot ask you to limit or give up these rights.

4. When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - ▷ Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - ▷ Cover emergency services by out-of-network providers.
  - ▷ Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - ▷ Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, please contact SCL Health Customer Service at 1-866-665-2636.
If we are unable to resolve your complaint, you may contact the No Surprises Helpdesk at 1-800-985-3059.

Please visit https://www.cms.gov/nosurprises/consumers for more information about your rights under Federal law.

Patients with Colorado-based health plans (your ID card will have “CO-DOI” printed on it) may also contact the Colorado State Division of Insurance at 303-894-7490 or 1-800-930-3745, or visit https://doi.colorado.gov/for-consumers/file-a-complaint

Select the person signing the form ✓ Signature complete!

☐ Verbal Consent

☐

Patient ☑ CHAVEZ , DANIEL ◉

Other ☐

Relationship to Patient: Self ◉

Reason Patient Unable to Sign: --

Patient or Authorized Representative Signature
Electronically signed on 03/31/2023, 7:59 AM

2nd Witness Signature
Witness: Electronically witnessed by:
Lawrence, Suellen: S061526
03/31/2023 07:59:40 am

SCL Health
GOOD SAMARITAN
Surprise Billing Disclosure – Colorado
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